No. 80811-2

THE SUPREME COURT OF THE STATE OF WASHINGTON

JAMES TOMLINSON,

Petitioner,

v.

PUGET SOUND FREIGHT LINES and
DEPARTMENT OF LABOR & INDUSTRIES,

Respondents.

SUPPLEMENTAL BRIEF OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Table of Cases

Statutes

Regulations and Rules

Other Authorities

A. ISSUES

1. RCW 51.32.080(5) provides that when determining permanent partial disability under the Industrial Insurance Act, and the injured body part was "already...permanently partially disabled" when the industrial injury occurred, the already-existing disability should not be compensated. As a matter of law, does the presence of arthritis, without proof that the arthritis caused loss of function, prove permanent partial disability?

2. Permanent partial disability for an industrial injury is not addressed until the injury becomes fixed and stable, which may not happen until long after the injury occurred. Consequently, determining whether a condition that preexisted an industrial injury was permanently partially disabling requires evaluating the condition *retrospectively*. As a matter of law, a condition is not permanent if it can be changed by medical treatment. Where treatment *after* an industrial injury changed (here, literally removed[1]) an alleged preexisting permanently disabling condition, should the post-injury change be taken into account when determining whether the condition, at the time of the industrial injury, was in fact permanent?

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[1] Certified Appeal Board Record (CABR) TRANSCRIPTS, Smith testimony, p. 50 line 17 p. 51 line 15; CABR EXHIBITS, Chaplin testimony, p. 51 lines 7-18.

B. STATEMENT OF THE CASE

On July 21, 1999, at work as a dispatcher for Puget Sound Freight Lines ("PSFL"), James Tomlinson fell down a flight of 13 stairs, striking his knee as he went.[2] At first could not get up because the knee felt locked.[3] He brought a claim under the Industrial Insurance Act ("IIA"), Title 51 RCW, which the Department of Labor and Industries allowed. PSFL did not appeal. (PSFL is a self-insuring employer under the IIA, so is responsible for paying Tomlinson's benefits.[4])

Tomlinson was referred to orthopedic surgeon John Jiganti, MD for evaluation and treatment of the knee. After some months of conservative treatment failed,[5] the knee was replaced with a prosthetic joint, twice.[6] The outcome was poor.[7] Nothing more could be done, and treatment ended.[8]

All that remained to do was address permanent partial disability ("PPD") and close the claim. In IIA claims, determination of PPD involves

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[2] CABR TRANSCRIPTS, Tomlinson testimony, p. 5 lines 39-51; p. 6 lines 7-19; and p. 6 lines 31-37. *See also* CABR TRANSCRIPTS, Smith testimony, p. 23 line 23 - p. 24 line 1.

[3] CABR EXHIBITS, Chaplin testimony, p. 13 lines 1-8.

[4] CABR 10 line 4. *See* RCW Chapter 51.14.

[5] *Id.*, p. 8 lines 16-25.

[6] CABR Jiganti testimony, p. 8 lines 16-25, and p. 10 lines 16-24.

[7] *Id.*, p. 10 lines 25 - p. 11 line 12.

[8] *Id.*, p. 11 lines 13-16.

two sets of actions, the first medical and second legal. First, a physician or physicians determine[9] whether an injury for which a claim was allowed has become medically fixed and stable,[10] and if so, whether the injury resulted in permanent impairment, and the extent of impairment. Then the Department applies the law (RCW 51.32.080 and related regulations) to the medical facts to determine whether PPD benefits are owed, and if so, how much. PSFL chose orthopedic surgeons James Smith, MD and David Chaplin, MD to address permanent impairment. The knee was first determined to be fixed and stable in December of 2000.[11] Both Dr. Smith and Dr. Chaplin determined permanent total impairment to be 75 percent of the leg, due

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[9] *See* McIndoe v. Dep't of Labor & Indus., *supra*, 144 Wn.2d at 265. *See also* Brannan v. Dep't of Labor & Indus.,104 Wn.2d 55, 56, 700 P.2d 1139 (1985) ("Department of Labor and Industries regulations [] require medical or osteopathic physicians or surgeons to rate permanent partial disabilities")

[10] *See* Pend Oreille Mines & Metals Co. v. Dep't of Labor & Indus., *supra*, 64 Wn.2d at 272 ("A workman may not be rated for permanent total disability until his condition becomes static or fixed"). (The difference between *total* and *partial* is immaterial; the material difference is between *temporary* and *permanent*. *See* Hubbard v. Dep't of Labor & Indus., below.) *See also* Solven v. Dep't of Labor & Indus., 101 Wn. App. 189, 196, 2 P.3d 492, *review denied*, 142 Wn.2d 1012, 16 P.3d 1265 (2000) ("condition of claimant must be 'fixed' before Department can give permanent partial disability rating," citation omitted). *See also* WAC 296-20-01002.

[11] The "leg" meaning "the leg above the knee joint with short thigh stump (3 inches or less below the tuberosity of ischium)." RCW 51.32.080(1)(a). The first date a physician explicitly said the knee was fixed and stable was Dr. Chaplin, on November 12, 2002. CABR EXHIBITS, Chaplin testimony, p. 11 lines 14-15 and p. 25 lines 3-10. Dr. Smith determined permanent impairment in December of 2000 (CABR TRANSCRIPTS, Smith testimony p. 23 lines 1-17), implying fixity and stability.

solely and entirely to the poor result from TKR.[12] Dr. Jiganti concurred.[13] PSFL accepted the 75 percent permanent impairment rating.[14]

The Department, however, ordered PPD not of 75 percent, but of 25 percent.[15] RCW 51.32.080 at subsection (5) directs that where an industrial injury causes permanent partial disability to a part of the body "already [*i.e.*, at the time of the industrial injury] permanently partially disabled," PPD be reduced by the amount of the preexisting disability. The Department concluded, based on written submissions from Drs. Chaplin and Smith, that at the time of the industrial injury Tomlinson's leg was already 50 percent permanently disabled, by arthritis. Arthritis means degenerative loss of the

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[12] *See* CABR TRANSCRIPTS, Smith testimony, p. 29 line 45 - p. 30 line 9; CABR EXHIBITS, Chaplin deposition, p. 52 lines 9-15.

No law expressly adopts the *AMA Guides* as the basis for rating permanent partial disability, but in practice the *Guides* govern. *See* In re Bertha Ramirez, No. 03 14933 (Bd. of Indus. Ins. Appeals, Sept. 1, 2004). The parts of the *Guides* discussed in testimony appear at CABR EXHIBITS.

Under the *Guides*, any score below 50 is "poor"; Dr. Smith scored Tomlinson 33. Smith testimony, p. 52 lines 23-35. "Poor" outcome from TKR equates to 75 percent loss of the leg. Smith testimony, p. 52 lines 37-51. The only worse disability of the leg is 100 percent amputation value. *Id.*, p. 53, lines 1-13; Chaplin testimony, p. 61 lines 16-24.

[13] CABR EXHIBITS, Jiganti testimony p. 12 lines 1-18; p. 26 line 23 - p. 24 line 8.

[14] CABR TRANSCRIPTS, Smith testimony, p. 26 lines 21-24 (statement by PSFL's attorney). *See also Verbatim Report of Proceedings* (VRP), p. 4 lines 18-25, and p. 5 lines 1-10.

[15] CABR 20 (the order from which this appeal originated).: "The department is ordered to pay you a permanent partial disability award of 75% of the amputation value of the left leg above [the] knee joint with short thigh stump (3" or below the tuberosity of ischium[,]" less what the Department concluded was preexisting permanent partial disability. PSFL paid that disability.

cartilage that separates the upper and lower leg bones.[16]

On appeal at the Board of Industrial Insurance Appeals, *Drs. Chaplin and Smith testified that their opinions about preexisting disability were based solely and entirely on measurement of cartilage thickness in an x-ray.*[17] The Board applies a well-reasoned rule (addressed at p. 17 below) that disability from arthritis cannot be proved by x-ray; rather (as required by this court; see p. 17 below), *disability requires proof of functional loss.* Drs. Chaplin and Smith were not asked whether they believed that, at the time of the industrial injury, Tomlinson's arthritis was causing functional loss, let alone functional loss that was disabling and permanent; and they expressed no opinions about it.[18]

Drs. Chaplin and Smith testified that, based on the extent of arthritis in Tomlinson's x-rays, they would expect him to have had some symptoms,

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[16] CABR EXHIBITS, Jiganti testimony, p. 18 lines 6-20. CABR TRANSCRIPTS, Smith testimony, p. 15 lines 11-13. CABR EXHIBITS, Chaplin testimony, p. 40 line 19 - p. 41 line 20.

[17] CABR TRANSCRIPTS, Smith testimony, p. 30 lines 11-43; p. 32 lines 23-47 ("by definition," arthritis in the knee is defined by cartilage thickness shown by x-ray. Dr. Smith was referencing CABR EXHIBITS, *Guides* p. 544, "Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals); Smith testimony, p. 60 lines 45-47 ("even the millimeter description by the AMA is not precise, but you've got to use something"). CABR EXHIBITS, Chaplin testimony, p. 43 line 20 - p. 44 line 18, and p. 46 line 23 - p. 47 line 7.

[18] In particular, see CABR TRANSCRIPTS, smith testimony, p. 36 line 21 - p. 37 line 7 (where Dr. Smith said he did not recall PSFL asking him to form an opinion about Tomlinson's condition at the time of Smith's examinations).

intermittently.[19] Attending surgeon Jiganti testified that functional loss cannot be attributed to arthritis without physical examination,[20] and that to try to do so would be "guessing."[21] Neither he, nor Drs. Chaplin and Smith, examined Tomlinson until after the industrial injury.[22] Dr. Jiganti testified further that (1) arthritis does not imply functional loss;[23] (2) whether arthritis was causing symptoms at any particular time cannot be inferred from x-rays,[24] and to do so would be speculation;[25] (3) while arthritis as advanced as Tomlinson's, by x-ray,[26] would be expected to cause some symptoms episodically, even severe arthritis does not imply severe symptoms;[27]

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[19] CABR TRANSCRIPTS, Smith testimony, p. 18 line 39 - p. 19 line 52, and p. 20 line 35 - p. 21 line 3; CABR EXHIBITS, Chaplin testimony, p. 32 line 20 - p. 33 line 1 and p. 41 line 24 - p. 42 line 4, and 49 line 19 - p. 50 line 3.

[20] CABR EXHIBITS, Jiganti testimony, p. 14 lines 8-13.

[21] *Id.*, p. 15 lines 9-13.

[22] Dr. Jiganti first saw Tomlinson on July 27, 1999. *Id.*, p. 4 lines 11-13. Dr. Smith first saw Tomlinson on July 21, 2000. CABR TRANSCRIPTS, Smith testimony, p. 23 lines 1-17. Dr. Chaplin first saw Tomlinson on Nov. 12, 2002. CABR EXHIBITS, Chaplin testimony, p. 11 lines 14-15.

[23] *Id.*, p. 7 lines 9-15.

[24] *Id.*, p. 7 lines 2-4 and p. 21 lines 11-13.

[25] *Id.*, p. 20 line 7 - p. 21 line 24.

[26] Characterized as "bone-on-bone." *See id.*, p. 18 line 21 - p. 19 line 3, and p. 22 lines 3-15. Dr. Smith characterized this degree of arthritis as "advanced" (CABR TRANSCRIPTS, Smith testimony, p. 17 lines 19-35), or "moderately advanced" (*id.*, p. 26 lines 43-51). Dr. Chaplin characterized it as "well advanced or severe." CABR EXHIBITS, Chaplin testimony, p. 40 lines 12-18.

[27] *Id.*, p. 7 lines 5-8.

episodes of symptoms, even repeated over many years, do not imply functional impairment or disability;[28] and presence of arthritis advanced enough to cause symptoms does not imply permanent functional loss.[29]

The record shows strong circumstantial evidence that at the time of injury Tomlinson was *not* disabled. Before the industrial injury he had experienced episodes of pain in *both* knees,[30] for many years.[31] However, at the time of the industrial injury he had not seen a doctor for his knees in four years.[32] At that time no clinical findings of disability (which Board authority requires[33]) were reported.[34] Until the injury he was able to perform all his work duties,[35] including frequently going up and down the stairs that he fell

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[28] *Id.*, p. 27 line 20 - p. 28 line 3.

[29] *Id.*, p. 27 lines 16-19. *Cf.* In re Lawrence Musick, No. 48 173 (Bd. of Indus. Ins. Appeals, Significant Decision, March 20, 1978) (where industrial injury was " the 'straw that broke the camel's back'," changing "severe, but intermittent, back problems prior to this injury... into continuous and more limiting and painful problems," employer was responsible for the disability).

[30] *See* CABR EXHIBITS, Chaplin testimony , p. 31 lines 14-18.

[31] In particular, see CABR TRANSCRIPTS, Smith testimony, p. 37 lines 29-39 (Tomlinson told him both knees had bothered him for many years).

[32] *See* CABR Smith testimony, p. 13 lines 13-19 and p. 20 lines 35-39. (There was evidence that his knee had been bothering him before the injury, see CABR Smith testimony at p. 21 line 41 - p. 22 line 27 – but not bad enough to seek medical care.)

[33] A conclusion of disability requires clinical findings. *See In re Walter H. Johnston*, No. 97 4529 (Bd. of Indus. Ins. Appeals, March 2, 1999), quoted at p. 19 below.

[34] *See* CABR EXHIBITS, Chaplin testimony, p. 37 line 19 - p. 38 line 9.

[35] CABR TRANSCRIPTS, Tomlinson testimony, p. 5 lines 39-51.

down on the injury date.[36] As far as the record shows, in Tomlinson's entire work life until the industrial injury he missed work because of his knee or knees just once – in the 1960s, when as an Air Force pilot he was taken off flight status for 30 days after an injury.[37]

Tomlinson testified that in March of 1992, a doctor told him that he might need knee replacement surgery in the future.[38] There is no evidence that after March of 1992, any doctor ever mentioned knee replacement again until after Tomlinson fell down the stairs and months of conservative treatment failed. PSFL's counsel asked whether, in Dr. Chaplin's opinion, Tomlinson would have needed TKR around "1999 or 2000, in that general ball park," even if the industrial injury had not happened; Dr. Chaplin answered that he was "not able to say that," because whether and when TKR is done depends on an individual's tolerance of symptoms.[39] Dr. Jiganti

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[36] *Id.*, p. 6 lines 1-5.

[37] *Id.*, p. 23 line 37 - p. 24 line 9. Dr. Smith testified that in the two-inch-thick stack of preinjury medical records PSFL gave him to review, he saw none that mentioned functional loss. Smith testimony, p. 56 line 45 - p. 57 line 11.

[38] *Id.*, p. p. 16 line 47 - p. 17. Tomlinson also told Dr. Smith that. CABR TRANSCRIPTS, Smith testimony, p. 25 lines 35-43 and p. 57 line 13 - p. 58 line 1. The record is unclear whether that was said regarding just the injured knee, or both knees. Tomlinson said both knees. *Id.*, p. 24 lines 11-41. A later medical record, summarizing history from Tomlinson, referred to the injured knee. However, it is understandable that in a discussion focusing on one leg, a figure of speech would be to say something like "a doctor told me that I might face having this knee replaced someday."

[39] CABR EXHIBITS, Chaplin testimony, p. 63 lines 1-20, then p. 64 line 13 - p. 65 line 9.

testified to the same effect.[40] (Logically, the testimony about future TKR did not prove disability at the time of injury. Moreover, even where future treatment is inevitable, an industrial injury that *accelerates* the need for treatment should make the employer wholly responsible for resultant disability.[41]) As far as the record shows, there is no reason to believe that if Tomlinson had not fallen down the stairs, his knee would not have lasted the rest of his work life.[42]

On April 1, 1992, a Veterans Administration doctor concluded that Tomlinson had 10 percent permanent disability of the knee attributable to arthritis.[43] The record shows only the opinion, not the basis for it. "The right to workers' compensation benefits is statutory, and a court will look to the provisions of *the Act* to determine whether a particular worker is entitled

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[40] CABR EXHIBITS, Jiganti testimony, p. 28 line 20 - p. 29 line 18 (of people who have the same arthritis by x-ray, some will undergo TKR and some will not).

[41] *See* In re Cecil L. Channing, No. 88 2165 (Bd. of Indus. Ins. Appeals, July 25, 1990), with emphasis added:

> We recognize that both Dr. Thorson and Dr. Winegar felt that Mr. Channing would have needed a total left knee replacement at some point in time, regardless of the industrial injury. However, we believe their testimony, taken as a whole, indicates that Mr. Channing needed total left knee replacement surgery **when he did** because of the industrial injury of July 2, 1980.

[42] At the time of the Board hearing he was 63 years old. CABR Transcripts, Tomlinson testimony at p. 5 lines 21-27. The Board hearing date was August 12, 2005. CABR Transcripts, p. 2 lines 33-39. On the injury date of July 21, 1999, he would have been 57 years old.

[43] See CABR EXHIBITS, Chaplin testimony, p. 35 lines 1-21.

to compensation."[44]

Finally, Tomlinson's preinjury history was wholly irrelevant to Drs. Chaplin and Smith's opinion that his leg was permanently disabled by arthritis before the industrial injury occurred. As they testified, their opinion depended solely and entirely on x-rays.[45]

C. SUMMARY OF ARGUMENT

There is no dispute that Tomlinson's fall down the stairs aggravated preexisting arthritis in his knee,[46] resulting in the TKR; or that PPD after TKR depends solely and entirely on how the injured worker's body accepts the prosthetic knee; or that for Tomlinson, TKR resulted in permanent impairment of 75 percent of the injured leg. Rather, the ultimate issue is

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[44] *Clauson v. Dep't of Labor & Indus.*, 130 Wn.2d 580, 584, 925 P.2d 624 (1996) (citation omitted, emphasis added). *See also Brand v. Dep't of Labor & Indus.*, 139 Wn.2d 659, 668, 989 P.2d 1111 (1999) (the IIA "is a self-contained system that provides specific procedures and remedies for injured workers"). *Cf. Cockle v. Dep't of Labor & Indus.*, 142 Wn.2d 801, 815, 16 P.3d 583 (2001) ("[w]e have already noted the danger in using foreign case law to interpret Title 51 RCW provisions" (citations omitted)).

[45] Dr. Chaplin said so explicitly. CABR EXHIBITS, Chaplin testimony, p. 50 lines 13-23.

[46] CABR 20 ("Medical evidence indicates that this injury is an aggravation of a preexisting condition diagnosed as degenerative arthritis of the left knee"); CABR EXHIBITS, Jiganti testimony, p. 6 lines 10-17; CABR TRANSCRIPTS, Chaplin testimony, p. 28 lines 6-11.

One of the most longstanding rules of workers' compensation law is that an employer takes an injured worker as he finds him, infirmities and all, and that where an industrial injury aggravates a preexisting condition, the employer is wholly responsible for the resulting disability. *See*, for example, *Lytle v. Dep't of Labor & Indus.*, 66 Wn.2d 745, 746, 405 P.2d 251 (1965), then *see Harper v. Dep't of Labor & Indus.*, 46 Wn.2d 404, 405, 281 P.2d 859 (1955).

whether at the time of injury, the leg injured in the fall was already permanently partially disabled by arthritis within the meaning of RCW 51.32.080(5).

The IIA is a self-contained, remedial plan of social insurance, governed by the statutes therein.[47] In RCW 51.32.080, the Act mandates payment of benefits for "permanent partial disability." Subsections (1), (2), and (3) of the statute identify bodily losses for which such benefits are payable, and address monetary values. Subsection (5) of the statute restricts, or limits, permanent partial disability benefits:

> Should a worker receive an injury to a member or part of his or her body **already**, from whatever cause, **permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability**...his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

(Emphasis added). This case presents an opportunity for the Court to determine what must be shown for a preexisting condition to qualify as a permanent partial disability under RCW 51.32.080(5). Statutes are read as a

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[47] Brand v. Dep't of Labor & Indus., 139 Wn.2d 659, 668, 989 P.2d 1111 (1999) (the "Industrial Insurance Act is a self-contained system that provides specific procedures and remedies for injured workers"). *See also*, RCW 51.12.010; Cockle v. Dep't of Labor & Indus., 142 Wn.2d 801, 811, 16 P.3d 583 (2001); Duskin v. Carlson, 136 Wn.2d 550, 557, 965 P.2d 611 (1998) ("The Department's interest is efficient administration of the State's social insurance system and minimizing associated costs to the industrial insurance fund" (citation omitted)); Clauson v. Dep't of Labor & Indus.,130 Wn.2d at 584, 925 P.2d 624 (1996).

whole, with regard for their purpose,[48] and restrictions on statutory remedies should be confined to their plain terms.[49] Tomlinson's arthritis was not permanently partially disabling, so subsection (5) should not apply.

"Permanent partial disability" and "permanently partially disabled" are not defined in the IIA, but nevertheless have plain meaning under well-settled authority. "Permanent" and "permanently" mean *fixed and stable*: not changeable by medical treatment; constant, not variable; not temporary, but lifelong. In determining, retrospectively, whether a condition present at the time of injury was permanent, the finder of fact should have to consider whether the condition was subsequently changed by treatment. Here, TKR eliminated Tomlinson's arthritis.

This court has settled that "disabled" and "disability" mean *functionally impaired.* There is no evidence, let alone substantial evidence, that when the industrial injury occurred, Tomlinson's knee was functionally impaired; rather, there is substantial evidence to the contrary. Further, the Board of Industrial Insurance Appeals has held repeatedly that x-ray evidence of arthritis does not prove functional loss. Because Tomlinson's arthritis was not permanent and disabling when the industrial injury

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[48] Department of Labor & Indus. v. Gongyin, 154 Wn.2d 38, 44-45, 109 P.3d 816 (2005).

[49] *Cerrillo v. Esparza*, 158 Wn.2d 194, 202, 142 P.3d 155 (2006).

occurred, RCW 51.32.080(5) should not apply.

The import of this case goes far beyond knee injuries that result in TKR. To apply subsection (5) based solely on x-ray evidence of arthritis, without evidence of functional disability, will seriously undermine the IIA's remedial intent for *many* injuries involving joints, because all joints have articular cartilage,[50] or the equivalent (for example, especially vertebral discs in the spine). In many of those cases, the Court of Appeals decision will enable the Department and self-insuring employers to pay less PPD than the injured worker's true disability – even none at all[51] – then sit back and see whether the worker will appeal, or just give up. Surely many will give up, rather than risk more delay, substantial expert witness costs, and possibly an attorney fee, for an uncertain outcome. In the relatively few cases when disabled workers will fight and win, the Department and self-insuring employers can spread their litigation cost over their pool of claims; and if in the end they have to pay more PPD, they will have benefitted from the delay because they pay no interest on PPD benefits withheld.[52] In short, the

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[50] CABR TRANSCRIPTS, Smith testimony, p. 14 lines 39-47.

[51] Under the *Guides*, disability after TKR can be "good," "fair," or "poor." CABR EXHIBITS, AMA *Guides* page 547. If Tomlinson's outcome had been good or fair, but still partially disabling, he would have gotten no PPD at all, because the impairment ratings for those outcomes are less than 50 percent of the leg.

[52] *See* RCW 51.52.135(1) and (2). In appeals initiated by an injured worker, interest is payable only on temporary total disability, not other benefits.

remedial intent of the PPD statute[53] will be undermined. Further, contrary to the intent of the PPD statute,[54] the litigation loads of the Board and the courts increase (moreover, permanently, since each determination will have to be fact specific).

The court should reiterate that PPD means functional impairment; hold that in determining whether a preinjury condition was "permanent" under RCW 51.32.080(5), the fact finder should consider not only treatment up to the injury date, but also subsequent treatment; and hold that for arthritis to be a "permanent partial disability," subsection (5) requires not only x-ray evidence that at the time of injury arthritis was present, but also clinical findings that the arthritis was causing permanent functional loss.

D. ARGUMENT

1. At the time of his industrial injury Tomlinson's knee was not "permanently partially disabled" because the arthritis was not permanent.

For the purpose of subsection (5), what does "permanently partially disabled" mean? The IIA does not define "permanently" or "permanent," or "disabled."[55] "Where a statute does not define a term, rules of statutory

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[53] *See* RCW 51.04.010.

[54] *See* RCW 51.32.080(3)(a) (the statute means to "reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities ...).

[55] There is a definition for "permanent partial disability" in the "Definitions" section of the IIA, at RCW 51.08.150, but it is unhelpful.

construction require us to give the term its plain and ordinary meaning, which we derive from a dictionary if possible."[56]

The plain and ordinary meaning of "permanently" and "permanent," in the context of disability, can be derived from a dictionary, and in fact the Court of Appeals recently did so, in Summers v. Great S. Life Ins. Co., 130 Wn. App. 209, 122 P.3d 195 (2005), *review denied*, 157 Wn.2d 1025, 142 P.3d 609 (2006). The court reasoned as follows:

> **[The term] "permanent" is a term of common understanding; it is not ambiguous.** Under the definition put forth in *Richards* and other cases, "permanent" refers to "a state of indefinite continuance...**something incapable of alteration, fixed or immutable."** 1C JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE, § 641, at 206 (1981). Under this definition, "**it must appear that the disability will probably continue for the remainder of the insured's life.**" APPLEMAN, *supra*, § 641, at 206; ***see also* BLACK'S LAW DICTIONARY 1139 (6th ed. 1990) (defining "permanent disability" as "one which will remain substantially the same during the remainder of worker's compensation claimant's life...").

130 Wn. App. at 216 (emphasis added, citations omitted).

Summers cited four precedents for the meaning of "permanent," three of them IIA decisions: Hiatt v. Dep't of Labor & Indus., 48 Wn.2d 843, 297 P.2d 244 (1956), Williams v. Virginia Mason Med. Ctr., 75 Wn. App. 582, 880 P.2d 539 (1975), and Shea v. Dep't of Labor & Indus., 12 Wn. App.

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[56] McClarty v. Totem Electric, 157 Wn.2d 214, 225, 137 P.3d 844 (2006) (citations omitted).

410, 415, 529 P.2d 1131 (1974), *review denied*, 85 Wn.2d 1009 (1975). In *Hiatt*, the Supreme Court adopted this statement:

> Except in the cases of permanent total disability that are specifically described in the statute, we believe a total **disability should not be declared to be permanent unless it appears pretty clearly that the affliction will not yield to treatment**, and that the workman will never be able to work at any gainful occupation.

48 Wn.2d 845-46 (citation and internal punctuation omitted, emphasis added.) A few sentences later the court endorsed this definition of "permanent," from *Webster's New International Dictionary* (2d ed. 1954):

> Continuing or enduring in the same state, status, place, or the like, without fundamental or marked change; **not subject to fluctuation or alteration**; fixed or intended to be fixed; lasting; abiding; stable; not temporary or transient.

Id. (emphasis added). Then, *Hiatt* concluded:

> **The use of the word "permanent" together with "disability" indicates the character of the disability. It signifies that the disability has expectedly an unchangeable existence; that the physical condition arising from the injury is fixed, lasting, and stable. A person whose condition is remediable is not permanently disabled.**

Id. (emphasis added). Similarly, the court said, in *Williams*:

> Permanent partial disability has been defined in case law as a partial incapacity to work as measured by loss of bodily function. ... [It] involve[s] the loss of working ability due to an industrial injury or condition which is **"permanent", that is**, an injury or condition which is fixed, lasting, stable, and **not remediable**.

75 Wn. App. at 585 (citations omitted, emphasis added). In *Shea*, the court said:

> When the disabling condition proximately caused by an injury is **no longer remedial** and its character has expectedly **an unchangeable existence**, the resultant disability is said to be permanent.

12 Wn. App. at 415 (emphasis added).

Leaving aside for the moment the question of whether, when Tomlinson fell down the stairs, his arthritis was disabling, the record is clear that the arthritis was not "permanent." Symptoms were intermittent – the antithesis of "fixed and stable." The arthritis was removed by TKR. In other words, both the arthritis, and its symptoms, in fact were temporary.

> The words "permanent" and "temporary" are antonyms of each other and readily occur to the ordinary mind as such. A disability that is transient or temporary cannot be a permanent one.

Summers, 130 Wn. App. at 215 (emphasis added). *See also Hubbard v. Dep't of Labor & Indus.*, 140 Wn.2d 35, 38 n.1, 992 P.2d 1002 (2000) ("The [IIA] contemplates two separate and distinct disability classifications, temporary and permanent[.]").

2. At the time of his industrial injury Tomlinson's knee was not "permanently partially disabled" because the arthritis was not disabling.

In a long line of cases spanning more than half a century, this court has held that permanent partial disability means loss of bodily function. *See*, most recently, *Willoughby v. Dep't of Labor & Indus.*, 147 Wn.2d 725, 735, 57 P.3d 611 (2002) (endorsing that "the sole purpose of PPD awards is to

compensate for loss of bodily functions").[57]

Similarly, the Board, in several decisions spanning 16 years, has held that disability for arthritis cannot be proved by x-rays, but requires evidence that the arthritis impairs function. In *In re Richard P. Murray*, No. 87 0440 (Bd. of Indus. Ins. Appeals, Jan. 25, 1988), the Board said:

> **X-ray findings, while objective in that they can be seen, are not, solely by themselves, proof of loss of physical function. Disability, not degenerative changes, is the issue here.**

(Emphasis added.) In *In re Mariah Smith*, No. 89 1277 (Bd. of Indus. Ins. Appeals, Oct. 25, 1990), the Board said "the rule" is that **"[t]he mere existence of pre-existing degenerative changes does not establish pre-existing disability."** In *In re William P. Nussbaum*, No. 90 3176 (Bd. of Indus. Ins. Appeals, May 12, 1992), the Board said:

> **There is no evidence that Mr. Nussbaum suffered any impairment, loss of function, or disability to his right leg as a result of preexisting degenerative arthritic changes in that knee.** It appears to us, **based on this record**, that **the industrial injury** of December 19, 1988 **made active the latent condition of degenerative arthritis.** Thus the resulting disability is attributable to the industrial injury. *Miller v. Dep.t of Labor & Indus.*, 200 Wash. 674 (1939).

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[57] *See also* *Harry v. Buse Timber & Sales, Inc.*, 134 Wn. App. 739, 744, 132 P.3d 1122 (2006) ("A permanent partial disability is an injury or occupational disease that causes the loss, or loss of use, of a particular body part," citing *McIndoe v. Dep't of Labor & Indus.*, 144 Wn.2d at 256-57); *Hubbard v. Dep't of Labor & Indus.*, 140 Wn.2d at 47 ("once the condition is fixed, permanent partial disability compensates the claimant for future lost earning capacity measured by a percentage loss of bodily function" (citation omitted)); *Dowell v. Dep't of Labor & Indus.*, 51 Wn.2d 428, 433, 319 P.2d 843 (1957) ("permanent partial disability is a partial incapacity to work as measured by loss of bodily function").

(Emphasis added.) In *In re Walter H. Johnston*, No. 974529 (Bd. of Indus. Ins. Appeals, March 2, 1999), the Board said that **"Although degenerative changes were apparent on x-ray, without clinical findings they are not enough to support a disability award."**[58] Most recently, in *In re Leonard Norgren*, No. 04 18211 (Bd. of Indus. Ins. Appeals, Jan.12 2006), the Board explained:

> In an effort to enhance understanding of the term "disability," the court in *Henson [v. Dep't of Labor & Indus.*, 15 Wn.2d 384 (1942)] related disability to its negative effect upon an individual's physical or mental functioning as well as his or her earning capacity. **Something more than existence of prior conditions requiring periodic medical attention was contemplated.** In the context of second injury fund relief,[59] **a "preexisting disability" is more than a mere preexisting medical condition and must, in some fashion, permanently impact on the worker's physical and/or mental functioning.**

(Emphasis added).

Here there is *no* evidence, let alone substantial evidence, that at the time of the industrial injury the arthritis in Tomlinson's knee was permanent and disabling. On this record, RCW 51.32.080(5) should not apply.

E. REQUEST FOR ATTORNEY FEE

If Tomlinson prevails, then pursuant to RAP 18.1 and RCW

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[58] *See also* *In re Joseph W. Felder*, No 06 18522 (Bd. of Indus. Ins. Appeals, January 5, 2008) (Dr. Robinson said the diagnostic films he obtained would have supported the need for total replacement of both knees at that time. On the other hand, according to Dr. Paul Benca, the worker's clinical findings were not sufficiently severe at that time to justify the procedure).

[59] That context is immaterial to this appeal.

51.52.130, he asks the court to order Puget Sound Freight Lines to pay his costs and a reasonable attorney fee for work before this court. Tomlinson further requests that, if he prevails, the court to remand to the Court of Appeals and the superior court to award costs and reasonable fees, against Puget Sound Freight Lines, for this appeal in those courts.

F. CONCLUSION

Where the record does not show that arthritis present at the time of injury was permanently disabling, PPD benefits should be awarded under RCW 51.32.030 for the full disability the injury caused; there should be no reduction under RCW 51.32.080(5). In holding that subsection (5) should apply, the Court of Appeals erred. This court should reverse; order the Department to order PSFL to pay Tomlinson permanent partial disability of 75 percent of his left leg above the knee joint with short thigh stump (3 inches or less below the tuberosity of ischium), less the 25 percent PSFL has already paid; and order costs and attorney fees as requested above.

DATED this 1 of July 2008.

Respectfully submitted,

RUMBAUGH RIDEOUT BARNETT & ADKINS

Terry J. Barnett, WSB 8080, Attorneys for appellant Tomlinson

CERTIFICATE OF SERVICE

I certify that on this date I mailed a copy of the SUPPLEMENTAL BRIEF OF PETITIONER to:

Jerald P. Keene
Michael H. Weier
Reinisch Mackenzie, P.C.
10260 SW Greenburg Road, Suite 1250
Portland, OR 97223-5500

DATED this 1 day of July 2008.

Michelle Rhodes

Michelle E. Rhodes, Legal Assistant

Appendix A

RCW 51.08.150
"Permanent partial disability."

"Permanent partial disability" means the loss of either one foot, one leg, one hand, one arm, one eye, one or more fingers, one or more toes, any dislocation where ligaments were severed where repair is not complete, or any other injury known in surgery to be permanent partial disability.

[1961 c 23 § 51.08.150. Prior: 1957 c 70 § 17; prior: 1949 c 219 § 1, part; 1947 c 246 § 1, part; 1929 c 132 § 2, part; 1927 c 310 § 4, part; 1923 c 136 § 2, part; 1919 c 131 § 4, part; 1917 c 28 § 1, part; 1913 c 148 § 1, part; 1911 c 74 § 5, part; Rem. Supp. 1949 § 7679, part.]

RCW 51.12.010
Employments included — Declaration of policy.

There is a hazard in all employment and it is the purpose of this title to embrace all employments which are within the legislative jurisdiction of the state.

This title shall be liberally construed for the purpose of reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment.

[1972 ex.s. c 43 § 6; 1971 ex.s. c 289 § 2; 1961 c 23 § 51.12.010. Prior: 1959 c 55 § 1; 1955 c 74 § 2; prior: (i) 1947 c 281 § 1, part; 1943 c 210 § 1, part; 1939 c 41 § 1, part; 1937 c 211 § 1, part; 1927 c 310 § 1, part; 1921 c 182 § 1, part; 1919 c 131 § 1, part; 1911 c 74 § 2, part; Rem. Supp. 1947 § 7674, part. (ii) 1923 c 128 § 1, part; RRS § 7674a, part.]

RCW 51.32.080
Permanent partial disability — Specified — Unspecified, rules for classification — Injury after permanent partial disability.

(1)(a) Until July 1, 1993, for the permanent partial disabilities here specifically described, the injured worker shall receive compensation as follows:

LOSS BY AMPUTATION	
Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$54,000.00
Of leg at or above knee joint with functional stump	48,600.00
Of leg below knee joint	43,200.00
Of leg at ankle (Syme)	37,800.00
Of foot at mid-metatarsals	18,900.00
Of great toe with resection of metatarsal bone	11,340.00
Of great toe at metatarsophalangeal joint	6,804.00
Of great toe at interphalangeal joint	3,600.00
Of lesser toe (2nd to 5th) with resection of metatarsal bone	4,140.00
Of lesser toe at metatarsophalangeal joint	2,016.00
Of lesser toe at proximal interphalangeal joint	1,494.00
Of lesser toe at distal interphalangeal joint	378.00
Of arm at or above the deltoid insertion or by disarticulation at the shoulder	54,000.00
Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon	51,300.00
Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand	48,600.00
Of all fingers except the thumb at	29,160.00

A-3

metacarpophalangeal joints	
Of thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	19,440.00
Of thumb at interphalangeal joint	9,720.00
Of index finger at metacarpophalangeal joint or with resection of metacarpal bone	12,150.00
Of index finger at proximal interphalangeal joint	9,720.00
Of index finger at distal interphalangeal joint	5,346.00
Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone	9,720.00
Of middle finger at proximal interphalangeal joint	7,776.00
Of middle finger at distal interphalangeal joint	4,374.00
Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone	4,860.00
Of ring finger at proximal interphalangeal joint	3,888.00
Of ring finger at distal interphalangeal joint	2,430.00
Of little finger at metacarpophalangeal joint or with resection of metacarpal bone	2,430.00
Of little finger at proximal interphalangeal joint	1,944.00
Of little finger at distal interphalangeal joint	972.00
MISCELLANEOUS	
Loss of one eye by enucleation	21,600.00
Loss of central visual acuity in one eye	18,000.00

Complete loss of hearing in both ears	43,200.00
Complete loss of hearing in one ear	7,200.00

(b) Beginning on July 1, 1993, compensation under this subsection shall be computed as follows:

(i) Beginning on July 1, 1993, the compensation amounts for the specified disabilities listed in (a) of this subsection shall be increased by thirty-two percent; and

(ii) Beginning on July 1, 1994, and each July 1 thereafter, the compensation amounts for the specified disabilities listed in (a) of this subsection, as adjusted under (b)(i) of this subsection, shall be readjusted to reflect the percentage change in the consumer price index, calculated as follows: The index for the calendar year preceding the year in which the July calculation is made, to be known as "calendar year A," is divided by the index for the calendar year preceding calendar year A, and the resulting ratio is multiplied by the compensation amount in effect on June 30 immediately preceding the July 1st on which the respective calculation is made. For the purposes of this subsection, "index" means the same as the definition in RCW 2.12.037(1).

(2) Compensation for amputation of a member or part thereof at a site other than those specified in subsection (1) of this section, and for loss of central visual acuity and loss of hearing other than complete, shall be in proportion to that which such other amputation or partial loss of visual acuity or hearing most closely resembles and approximates. Compensation shall be calculated based on the adjusted schedule of compensation in effect for the respective time period as prescribed in subsection (1) of this section.

(3)(a) Compensation for any other permanent partial disability not involving amputation shall be in the proportion which the extent of such other disability, called unspecified disability, shall bear to the disabilities specified in subsection (1) of this section, which most closely resembles and approximates in degree of disability such other disability, and compensation for any other unspecified permanent partial disability shall be in an amount as measured and compared to total bodily impairment. To reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities, the department shall enact rules having the force of law classifying such disabilities in the proportion which the department shall determine such disabilities reasonably bear to total bodily impairment. In enacting such rules, the department shall give consideration to, but need not necessarily adopt, any nationally recognized medical standards or guides for determining various bodily impairments.

(b) Until July 1, 1993, for purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be deemed to be ninety thousand dollars. Beginning on July 1, 1993, for purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be adjusted as follows:

(i) Beginning on July 1, 1993, the amount payable for total bodily impairment under this section shall be increased to one hundred eighteen thousand eight hundred dollars; and

(ii) Beginning on July 1, 1994, and each July 1 thereafter, the amount payable for total bodily impairment prescribed in (b)(i) of this subsection shall be adjusted as provided in subsection (1)(b)(ii) of this section.

(c) Until July 1, 1993, the total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed the sum of ninety thousand dollars. Beginning on July 1, 1993, total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed a sum calculated as follows:

(i) Beginning on July 1, 1993, the sum shall be increased to one hundred eighteen thousand eight hundred dollars; and

(ii) Beginning on July 1, 1994, and each July 1 thereafter, the sum prescribed in (b)(i) of this subsection shall be adjusted as provided in subsection (1)(b)(ii) of this section.

(4) If permanent partial disability compensation is followed by permanent total disability compensation, any portion of the permanent partial disability compensation which exceeds the amount that would have been paid the injured worker if permanent total disability compensation had been paid in the first instance shall be, at the choosing of the injured worker, either: (a) Deducted from the worker's monthly pension benefits in an amount not to exceed twenty-five percent of the monthly amount due from the department or self-insurer or one-sixth of the total overpayment, whichever is less; or (b) deducted from the pension reserve of such injured worker and his or her monthly compensation payments shall be reduced accordingly.

(5) Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent

partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

(6) When the compensation provided for in subsections (1) through (3) of this section exceeds three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, payment shall be made in monthly payments in accordance with the schedule of temporary total disability payments set forth in RCW 51.32.090 until such compensation is paid to the injured worker in full, except that the first monthly payment shall be in an amount equal to three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, and interest shall be paid at the rate of eight percent on the unpaid balance of such compensation commencing with the second monthly payment. However, upon application of the injured worker or survivor the monthly payment may be converted, in whole or in part, into a lump sum payment, in which event the monthly payment shall cease in whole or in part. Such conversion may be made only upon written application of the injured worker or survivor to the department and shall rest in the discretion of the department depending upon the merits of each individual application. Upon the death of a worker all unpaid installments accrued shall be paid according to the payment schedule established prior to the death of the worker to the widow or widower, or if there is no widow or widower surviving, to the dependent children of such claimant, and if there are no such dependent children, then to such other dependents as defined by this title.

(7) Awards payable under this section are governed by the schedule in effect on the date of injury.

[2007 c 172 § 1; 1993 c 520 § 1; 1988 c 161 § 6; 1986 c 58 § 2; 1982 1st ex.s. c 20 § 2; 1979 c 104 § 1; 1977 ex.s. c 350 § 46; 1972 ex.s. c 43 § 21; 1971 ex.s. c 289 § 10; 1965 ex.s. c 165 § 1; 1961 c 274 § 3; 1961 c 23 § 51.32.080. Prior: 1957 c 70 § 32; prior: 1951 c 115 § 4; 1949 c 219 § 1, part; 1947 c 246 § 1, part; 1929 c 132 § 2, part; 1927 c 310 § 4, part; 1923 c 136 § 2, part; 1919 c 131 § 4, part; 1917 c 28 § 1, part; 1913 c 148 § 1, part; 1911 c 74 § 5, part; Rem. Supp. 1949 § 7679, part.]

Notes:

Application -- 2007 c 172: "This act applies to all pension orders issued on or after July 22, 2007." [2007 c 172 § 2.]

Effective date -- 1993 c 520: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [May 18, 1993]." [1993 c 520 § 2.]

Effective dates -- 1988 c 161: See note following RCW 51.32.050.

Effective date -- 1986 c 58 §§ 2 and 3: "Sections 2 and 3 of this act shall take effect on July 1, 1986." [1986 c 58 § 7.]

Effective date -- 1982 1st ex.s. c 20: See note following RCW 51.32.075.

RCW 51.52.130
Attorney and witness fees in court appeal.

(1) If, on appeal to the superior or appellate court from the decision and order of the board, said decision and order is reversed or modified and additional relief is granted to a worker or beneficiary, or in cases where a party other than the worker or beneficiary is the appealing party and the worker's or beneficiary's right to relief is sustained, a reasonable fee for the services of the worker's or beneficiary's attorney shall be fixed by the court. In fixing the fee the court shall take into consideration the fee or fees, if any, fixed by the director and the board for such attorney's services before the department and the board. If the court finds that the fee fixed by the director or by the board is inadequate for services performed before the department or board, or if the director or the board has fixed no fee for such services, then the court shall fix a fee for the attorney's services before the department, or the board, as the case may be, in addition to the fee fixed for the services in the court. If in a worker or beneficiary appeal the decision and order of the board is reversed or modified and if the accident fund or medical aid fund is affected by the litigation, or if in an appeal by the department or employer the worker or beneficiary's right to relief is sustained, or in an appeal by a worker involving a state fund employer with twenty-five employees or less, in which the department does not appear and defend, and the board order in favor of the employer is sustained, the attorney's fee fixed by the court, for services before the court only, and the fees of medical and other witnesses and the costs shall be payable out of the administrative fund of the department. In the case of self-insured employers, the attorney fees fixed by the court, for services before the court only, and the fees of medical and other witnesses and the costs shall be payable directly by the self-insured employer.

(2) In an appeal to the superior or appellate court involving the presumption established under RCW 51.32.185, the attorney's fee shall be payable as set forth under RCW 51.32.185.

[2007 c 490 § 4; 1993 c 122 § 1; 1982 c 63 § 23; 1977 ex.s. c 350 § 82; 1961 c 23 § 51.52.130. Prior: 1957 c 70 § 63; 1951 c 225 § 17; prior: 1949 c 219 § 6, part; 1943 c 280 § 1, part; 1931 c 90 § 1, part; 1929 c 132 § 6, part; 1927 c 310 § 8, part; 1911 c 74 § 20, part; Rem. Supp. 1949 § 7697, part.]

Notes:

Effective dates -- Implementation -- 1982 c 63: See note following RCW 51.32.095.

296-20-01001 << 296-20-01002 >> 296-20-015

WAC 296-20-01002 Washington State Register filings since 2003

Definitions.

Acceptance, accepted condition: Determination by a qualified representative of the department or self-insurer that reimbursement for the diagnosis and curative or rehabilitative treatment of a claimant's medical condition is the responsibility of the department or self-insurer. The condition being accepted must be specified by one or more diagnosis codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM).

Appointing authority: For the evidence-based prescription drug program of the participating agencies in the state purchased health care programs, appointing authority shall mean the following persons acting jointly: The administrator of the health care authority, the secretary of the department of social and health services, and the director of the department of labor and industries.

Attendant care: Those proper and necessary personal care services provided to maintain the worker in his or her residence. Refer to WAC 296-20-303 for more information.

Attending provider report: This type of report may also be referred to as a "60 day" or "special" report. The following information must be included in this type of report. Also, additional information may be requested by the department as needed.

(1) The condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings.

(2) Their relationship, if any, to the industrial injury or exposure.

(3) Outline of proposed treatment program, its length, components, and expected prognosis including an estimate of when treatment should be concluded and condition(s) stable. An estimated return to work date should be included. The probability, if any, of permanent partial disability resulting from industrial conditions should be noted.

(4) If the worker has not returned to work, the attending doctor should indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.

(5) If the worker has not returned to work, a doctor's estimate of physical capacities should be included with the report. If further information regarding physical capacities is needed or required, a performance-based physical capacities evaluation can be requested. Performance-based physical capacities evaluations should be conducted by a licensed occupational therapist or a licensed physical therapist. Performance-based physical capacities evaluations may also be conducted by other qualified professionals who provided performance-based physical capacities evaluations to the department prior to May 20, 1987, and who have received written approval to continue supplying this service based on formal department review of their qualifications.

Attending provider: For these rules, means a person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner. An attending provider actively treats an injured or ill worker.

Authorization: Notification by a qualified representative of the department or self-insurer that specific proper and necessary treatment, services, or equipment provided for the diagnosis and curative or rehabilitative treatment of an accepted condition will be reimbursed by the department or self-insurer.

Average wholesale price (AWP): A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

Baseline price (BLP): Is derived by calculating the mean average for all NDC's (National Drug Code) in a specific product group, determining the standard deviation, and calculating a new mean average using all prices within one standard deviation of the original mean average. "Baseline price" is a drug pricing mechanism developed and updated by First Data Bank.

Bundled codes: When a bundled code is covered, payment for them is subsumed by the payment for the codes or services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.) Bundled codes and services are identified in the fee schedules.

By report: BR (by report) in the value column of the fee schedules indicates that the value of this service is to be determined by report (BR) because the service is too unusual, variable or new to be assigned a unit value. The report

shall provide an adequate definition or description of the services or procedures that explain why the services or procedures (e.g., operative, medical, radiological, laboratory, pathology, or other similar service report) are too unusual, variable, or complex to be assigned a relative value unit, using any of the following as indicated:

(1) Diagnosis;

(2) Size, location and number of lesion(s) or procedure(s) where appropriate;

(3) Surgical procedure(s) and supplementary procedure(s);

(4) Whenever possible, list the nearest similar procedure by number according to the fee schedules;

(5) Estimated follow-up;

(6) Operative time;

(7) Describe in detail any service rendered and billed using an "unlisted" procedure code.

The department or self-insurer may adjust BR procedures when such action is indicated.

Chart notes: This type of documentation may also be referred to as "office" or "progress" notes. Providers must maintain charts and records in order to support and justify the services provided. "Chart" means a compendium of medical records on an individual patient. "Record" means dated reports supporting bills submitted to the department or self-insurer for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in a chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible, and shall include, but are not limited to:

(1) Date(s) of service;

(2) Patient's name and date of birth;

(3) Claim number;

(4) Name and title of the person performing the service;

(5) Chief complaint or reason for each visit;

(6) Pertinent medical history;

(7) Pertinent findings on examination;

(8) Medications and/or equipment/supplies prescribed or provided;

(9) Description of treatment (when applicable);

(10) Recommendations for additional treatments, procedures, or consultations;

(11) X rays, tests, and results; and

(12) Plan of treatment/care/outcome.

Consultation examination report: The following information must be included in this type of report. Additional information may be requested by the department as needed.

(1) A detailed history to establish:

(a) The type and severity of the industrial injury or occupational disease.

(b) The patient's previous physical and mental health.

(c) Any social and emotional factors which may effect recovery.

(2) A comparison history between history provided by attending doctor and injured worker, must be provided with exam.

(3) A detailed physical examination concerning all systems affected by the industrial accident.

(4) A general physical examination sufficient to demonstrate any preexisting impairments of function or concurrent condition.

(5) A complete diagnosis of all pathological conditions including ICD-9-CM codes found to be listed:

(a) Due solely to injury.

(b) Preexisting condition aggravated by the injury and the extent of aggravation.

(c) Other medical conditions neither related to nor aggravated by the injury but which may retard recovery.

(d) Coexisting disease (arthritis, congenital deformities, heart disease, etc.).

(6) Conclusions must include:

(a) Type of treatment recommended for each pathological condition and the probable duration of treatment.

(b) Expected degree of recovery from the industrial condition.

(c) Probability, if any, of permanent disability resulting from the industrial condition.

(d) Probability of returning to work.

(7) Reports of necessary, reasonable X-ray and laboratory studies to establish or confirm the diagnosis when indicated.

Doctor or attending doctor: For these rules, means a person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry. An attending doctor is a treating doctor.

Only those persons so licensed may sign report of accident forms, the provider's initial report, and certify time loss compensation; however, physician assistants (PAs) also may sign these forms pursuant to WAC 296-20-01501 (PAs may be "treating providers" pursuant to the definition contained in WAC 296-20-01002); and ARNPs may also sign these forms pursuant to WAC 296-23-241 (ARNPs may be "attending providers" consistent with the definition contained in WAC 296-20-01002).

Emergent hospital admission: Placement of the worker in an acute care hospital for treatment of a work related medical condition of an unforeseen or rapidly progressing nature which if not treated in an inpatient setting, is likely to jeopardize the workers health or treatment outcome.

Endorsing practitioner: A practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any nonpreferred drug in a given therapeutic class.

Fatal: When the attending doctor has reason to believe a worker has died as a result of an industrial injury or exposure, the doctor should notify the nearest department service location or the self-insurer immediately. Often an autopsy is required by the department or self-insurer. If so, it will be authorized by the service location manager or the self-insurer. Benefits payable include burial stipend and monthly payments to the surviving spouse and/or dependents.

Fee schedules or maximum fee schedule(s): The fee schedules consist of, but are not limited to, the following:

(a) Health Care Common Procedure Coding System Level I and II Codes, descriptions and modifiers that describe medical and other services, supplies and materials.

(b) Codes, descriptions and modifiers developed by the department.

(c) Relative value units (RVUs), calculated or assigned dollar values, percent-of-allowed-charges (POAC), or diagnostic related groups (DRGs), that set the maximum allowable fee for services rendered.

(d) Billing instructions or policies relating to the submission of bills by providers and the payment of bills by the department or self-insurer.

(e) Average wholesale price (AWP), baseline price (BLP), and policies related to the purchase of medications.

Health services provider or provider: For these rules means any person, firm, corporation, partnership, association, agency, institution, or other legal entity providing any kind of services related to the treatment of an industrially injured worker. It includes, but is not limited to, hospitals, medical doctors, dentists, chiropractors, vocational rehabilitation counselors, osteopathic physicians, pharmacists, podiatrists, physical therapists, occupational therapists, massage therapists, psychologists, naturopathic physicians, and durable medical equipment dealers.

Home nursing: Those nursing services that are proper and necessary to maintain the worker in his or her residence. These services must be provided through an agency licensed, certified or registered to provide home care, home health or hospice services. Refer to WAC 296-20-091 for more information.

Independent or separate procedure: Certain of the fee schedule's listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "independent procedure" is applicable.

Initial prescription drugs: Any drug prescribed for an alleged industrial injury or occupational disease during the initial visit.

Initial visit: The first visit to a healthcare provider during which the *Report of Industrial Injury or Occupational Disease* is completed and the worker files a claim for workers compensation.

Medical aid rules: The Washington Administrative Codes (WACs) that contain the administrative rules for medical and other services rendered to workers.

Modified work status: The worker is not able to return to their previous work, but is physically capable of carrying out work of a lighter nature. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self confidence.

Under RCW 51.32.090, when the employer has modified work available for the worker, the employer must furnish the doctor and the worker with a statement describing the available work in terms that will enable the doctor to relate the physical activities of the job to the worker's physical limitations and capabilities. The doctor shall then determine whether the worker is physically able to perform the work described. The employer may not increase the physical requirements of the job without requesting the opinion of the doctor as to the worker's ability to perform such additional work. If after a trial period of reemployment the worker is unable to continue with such work, the worker's time loss compensation will be resumed upon certification by the attending doctor.

If the employer has no modified work available, the department should be notified immediately, so vocational assessment can be conducted to determine whether the worker will require assistance in returning to work.

Nonemergent (elective) hospital admission: Placement of the worker in an acute care hospital for medical treatment of an accepted condition which may be safely scheduled in advance without jeopardizing the worker's health or treatment outcome.

Physician or attending physician (AP): For these rules, means any person licensed to perform one or more of the following professions: Medicine and surgery; or osteopathic medicine and surgery. An AP is a treating physician.

Practitioner or licensed health care provider: For these rules, means any person defined as a "doctor" under these rules, or licensed to practice one or more of the following professions: Audiology; physical therapy; occupational therapy; pharmacy; prosthetics; orthotics; psychology; nursing; advanced registered nurse practitioners (ARNPs); certified medical physician assistants or osteopathic physician assistants; and massage therapy.

Preferred drug list: The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased health care programs.

Proper and necessary:

(1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

(2) Under the Industrial Insurance Act, "proper and necessary" refers to those health care services which are:

(a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;

(b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;

(c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and

(d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

(3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

Refill: The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

Regular work status: The injured worker is physically capable of returning to his/her regular work. It is the duty of the attending doctor to notify the worker and the department or self-insurer, as the case may be, of the specific date of release to return to regular work. Compensation will be terminated on the release date. Further treatment can be allowed as requested by the attending doctor if the condition is not stationary and such treatment is needed and otherwise in order.

Temporary partial disability: Partial time loss compensation may be paid when the worker can return to work on a limited basis or return to a lesser paying job is necessitated by the accepted injury or condition. The worker must have a reduction in wages of more than five percent before consideration of partial time loss can be made. No partial time loss compensation can be paid after the worker's condition is stationary. **All time loss compensation must be certified by the attending doctor based on objective findings.**

Termination of treatment: When treatment is no longer required and/or the industrial condition is stabilized, a report indicating the date of stabilization should be submitted to the department or self-insurer. This is necessary to initiate closure of the industrial claim. The patient may require continued treatment for conditions not related to the industrial condition; however, financial responsibility for such care must be the patient's.

Therapeutic alternative: Drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses.

Therapeutic interchange: To dispense with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug.

Total permanent disability: Loss of both legs or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful employment. When the attending doctor feels a worker may be totally and permanently disabled, the attending doctor should communicate this information immediately to the department or self-insurer. A vocational evaluation and an independent rating of disability may be arranged by the department prior to a determination as to total permanent disability. Coverage for treatment does not usually continue after the date an injured worker is placed on pension.

Total temporary disability: Full-time loss compensation will be paid when the worker is unable to return to any type of reasonably continuous gainful employment as a direct result of an accepted industrial injury or exposure.

Treating provider: For these rules, means a person licensed to practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry;

optometry; advanced registered nurse practitioner (ARNP); and certified medical physician assistants or osteopathic physician assistants. A treating provider actively treats an injured or ill worker.

Unusual or unlisted procedure: Value of unlisted services or procedures should be substantiated "by report" (BR).

Utilization review: The assessment of a claimant's medical care to assure that it is proper and necessary and of good quality. This assessment typically considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the accepted condition being treated.

[Statutory Authority: 2007 c 263, RCW 51.04.020 and 51.04.030. 08-04-095, § 296-20-01002, filed 2/5/08, effective 2/22/08. Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-01002, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020, 51.04.030. 07-17-167, § 296-20-01002, filed 8/22/07, effective 9/22/07. Statutory Authority: 2004 c 65 and 2004 c 163. 04-22-085, § 296-20-01002, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-01002, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-01002, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-01002, filed 10/22/02, effective 12/1/02. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.060, 51.32.072, and 7.68.070. 01-18-041, § 296-20-01002, filed 8/29/01, effective 10/1/01. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-039, § 296-20-01002, filed 12/7/99, effective 1/8/00. Statutory Authority: RCW 51.04.030, 70.14.050 and 51.04.020(4). 95-16-031, § 296-20-01002, filed 7/21/95, effective 8/22/95. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-01002, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-20-01002, filed 12/1/92, effective 1/1/93; 92-05-041, § 296-20-01002, filed 2/13/92, effective 3/15/92. Statutory Authority: RCW 51.04.020. 90-14-009, § 296-20-01002, filed 6/25/90, effective 8/1/90. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-01002, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-01002, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-01002, filed 10/1/86, effective 11/1/86; 83-24-016 (Order 83-35), § 296-20-01002, filed 11/30/83, effective 1/1/84; 83-16-066 (Order 83-23), § 296-20-01002, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-01002, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-01002, filed 12/23/80, effective 3/1/81.]